BRIEF THERAPY

Myths, Methods, and Metaphors

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Pain control has been a specific area of my interest as long as I can remember. It may have been the circumstances of my upbringing that sparked my curiosity. I was three when my seven-year-old brother, Robert, was the victim of a hit-and-run accident. He spent months in casts on the sofa. My father, Milton Erickson, also experienced significant and daily pain as a result of his polio and postpolio syndrome. Both Robert and my father adjusted to major invasions of their personal comfort. The daily ongoing exposure allowed me to observe pain not as an occasional intruder, but as a fact of life. From an early age I understood pain as something that can come unexpectedly and can touch anyone. I also saw that it was NOT something that has to ruin one’s life: It may be an inconvenience, a problem, a challenge, but there is always room to improve.

I consider myself to have been fortunate, far more fortunate than I realized at the time, to discuss and advance ideas that I had, and to work together with my father in formulating approaches to solving problems. For clarity, I will refer to my father, Milton H. Erickson, M.D., as Erickson, but I do wish to note that I think of him as Dad.

The objective of this chapter is to propose five broad classifications within which hypnotic interventions for pain can be grouped. I will begin with a review of 11 hypnotic interventions for pain that were described by Erickson (1967). I will then show five broad categories within which the interventions can be flexibly invoked. Each category
will be illustrated with previously unpublished examples. It is my intent to illustrate the variety and range of possible interventions with pain problems.

Pain control was only one area of Erickson’s work. Among his greatest contributions to the behavioral sciences were his study, application, development, and advancement of hypnosis as an ethical, professional tool of therapy.

Hypnosis is a powerful therapeutic tool, the use of which demands much responsibility on the part of the practitioner. First and foremost in any health care setting are the needs and well-being of the patient. Pain control techniques, as well as all hypnotherapeutic measures, must be adjunct to the medical, physiological, and psychological treatment of the patient and are intended for use in synchrony with holistic health care measures by health care professionals.

Prior to working with a patient who is experiencing physiological pain, a therapist must have an understanding of the physiological and pathological processes affecting the patient. The therapist must clearly comprehend the pain process, the specific medical conditions affecting the patient, medications taken and their effects, and the potential ramifications of suggestions. I encourage all therapists seriously interested in working with pain patients to study pathophysiology and to explore the usefulness of pain.

Without this vital information, misapplication of concepts could compromise the natural protective mechanisms and healing processes of the body. Obviously, the therapist must work closely with the physician and other members of the health care team in order to ensure that efforts are harmoniously and accurately directed toward healing and enhancement of comfort.

A major responsibility of any therapist who wishes to diminish a patient’s response to pain is to teach that patient to recognize and heed warning signals that become masked or diminished.

Another therapist responsibility is individualizing treatment. In his therapeutic work, Erickson stressed the need to tailor therapy and treatment to complement the individual’s personality and situation. This concept is especially important in pain control interventions.

Some of Erickson’s (1967) applications of hypnosis for pain control were presented by him in April 1965, in Paris, at the International Congress for Hypnosis and Psychosomatic Medicine. The paper has been reprinted twice and has been elaborated on in Hypnosis: An Exploratory Casebook (Erickson & Rossi, 1979). I will briefly review each of these applications and then follow with five broader categories and illustrations.
Direct Suggestions for the Total Abolition of Pain

This procedure is suitable for a limited number of patients, and even when effective it may be limited in duration. For the few patients with a strong internal will and discipline, a suggestion or command, "You don't need to feel that," may provide temporary relief.

Permissive Indirect Hypnotic Abolition of Pain

These suggestions, similar in content to direct suggestions, differ in the way in which the information is offered. The suggestions are presented in a manner that may be more conducive to patient receptivity. The delivery of suggestions may occur in metaphors or in other indirect modes. I often use this type of approach: "Wouldn't it be nice if your leg were resting on something soft like a pile of shaving cream?" I have found that this approach often works well on hospitalized patients. The unconscious knows that beyond directing the patient toward medical care, and self-protection, the pain serves no useful purpose. The patient, motivated by the discomfort of pain, has the unconscious resources to mobilize the imagination. Images of more comfortable sensations may be conjured up in response to simple suggestions, such as this one.

Amnesia

Partial, selective, or complete amnesia for past pain may be employed as an element in the overall treatment. This occurs naturally and quite often when patients elect to absorb themselves in external events. Books, movies, and sporting events are examples of vehicles for this process.

Hypnotic Analgesia

Analgesia, or the reduction of the sensation of pain, may be employed through direct or indirect suggestion. Suggesting the patient experience numbness in the affected part of the body is a direct approach. Hypnotic suggestions involving snowdrifts, cool streams, or protective gloves could be utilized as indirect routes. Indirection also might be employed
by offering suggestions regarding a different body part than the affected or injured body part. For example, suggestions of comfort directed to the contralateral limb might be as effective as continuation of focus on the injured limb.

**Hypnotic Anesthesia**

Erickson described anesthesia, or the abolition of sensation, as best accomplished indirectly by building up psychological and emotional situations contradictory to the emotional experience of pain. One of my nephews, who is well versed in the use of hypnosis, described the following situation in which he used hypnotic anesthesia. Michael tripped on a ladder at a construction site and fell, damaging the muscle and tendon of his ankle and calf. Utilizing self-hypnosis, he reasoned that any limb so damaged that it hung limply surely had some nerve damage. If the nerve was damaged, it could not hurt. He sought prompt medical attention and remained entirely pain free for the next few days.

**Hypnotic Replacement or Substitution of Sensations**

An example frequently cited is that of replacing pain with an itch. The emotional content of the sensation also is diffused by the alteration of the perceived pain.

**Hypnotic Displacement of Pain**

Displacement of pain from one body part to another is a technique that Erickson used extensively. Erickson (1967) described an example of a patient suffering from metastatic cancer. Hypnotic suggestions were offered that effectively shifted the focus of sensation from the patient’s abdomen to the patient’s left hand. By shifting the focus, control is initiated and the threat associated with the central body part is displaced by distance.

**Hypnotic Dissociation**

Time and body disorientation can effectively produce a feeling of comfort. The patient can be reoriented in time to an earlier stage of illness when pain was a minor consideration. In body disorientation, patients are hypnotically induced to experience themselves apart from their
bodies. One of my aunts described her application of body dissociation on the occasion of having stitches removed following major surgery. The suture removal was something that she perceived as painful, and she had fainted on previous occasions. She stated, "I left my body on the bed and took my head and shoulders to the solarium at the end of the hall."

**Hypnotic Reinterpretation of the Pain Experience**

Full awareness of the patient's perception of pain is a prerequisite for successful reinterpretation of symptoms. Erickson (1967/1980) proposed a series of suggestions providing a transition from an experience of deep distress to one of milder discomfort. The example provided is that of "throbbling, nagging, grinding pain having been successfully reinterpreted as the unpleasant but not distressing experience of the rolling with a boat during a storm" (p. 243).

**Hypnotic Time Distortion**

The hypnotic phenomenon of time distortion was developed originally by Lynn Cooper and elaborated later by Cooper and Erickson in *Time Distortion in Hypnosis* (1959). The process involved is the manipulation of experiential time in relation to actual or clock time. Patients are encouraged to experience an extension of the time when they are relatively pain free, and to perceptually condense those intervals when the pain is problematic. Erickson found that once patients were trained in these techniques, the actual or clock time of the episodes of pain diminished, as well as the experiential time. This technique often is used in combination with amnesia for past pain.

**Hypnotic Suggestions Effecting a Diminution of Pain**

This technique involves systematically diminishing pain. The patient may be given suggestions, for example, that over the next hour his or her pain will diminish, perhaps imperceptibly at first, possibly only 1%. Ongoing suggestions are given over the course of therapy in which a larger and larger portion of the original pain fades away.

**TYPES OF HYPNOTIC PAIN CONTROL INTERVENTIONS**

Erickson's techniques of pain management have been classified into basic categories, but in application the techniques may be interwoven and combined. A variety of techniques may be utilized in any individual situation. The technique selected and the application process are the
product of therapeutic skills and goals, in the service of individual needs and personalities.

I propose the following broad categories for the classification of hypnotic pain control interventions. The eleven hypnotic procedures described by Erickson may be used flexibly within these categories.

1. Acceptance
2. Division into parts
3. Dissociation
4. Transformation
5. Resolution

This classification for interventions provides a framework within which the therapist may utilize Erickson’s techniques. Additionally, it may prove useful to evaluate case reports, and to stimulate and encourage the creative migration from one sensory modality to another.

Acceptance

Within this category fall techniques focused on adaptation to the experience of pain as part of life. Rather than change or manipulate the pain, changes are made within the life-style toward adaptation to the situation.

Erickson had exceptional abilities in encouraging patients to accept adverse conditions and to go forward in time. He did not distance himself from the individual in pain, but often encouraged the person to feel the pain, as it really was, for a few minutes. By confronting the pain and putting it into perspective within one’s life-style; the patient is released to go forward. The pain is reduced to a thread in the fabric of life. The focus of treatment is directed on the perspective of life.

Compromises with pain begin with the onset of symptomatology. Often the patient may choose a favorite pillow or sleeping position that reduces the discomfort. Muscular realignment takes place throughout the entire body, to guard, protect, or splint a weak or damaged part. Accepting the adjustments and the changes as they occur facilitates a positive outlook for the patient. Turning inward to discover “just what it will take to put the feelings into a state of balance and comfort” is a task that may encourage ongoing adjustments. To have already begun this is praiseworthy.
Looking out into a garden, one may see the flowers or the weeds. Finding the flowers in an overgrown weed patch may be a cumbersome task, but once the first flower is found, the next becomes easier to locate. Each comfort measure can blossom to provide reminders of past successes, of the unexpected resourcefulness that we have within, and of the promise of future comfort.

Pain control measures may focus on acceptance of all or part of the sensation, either intact or in an altered form. Acceptance frees the patient to flow with the events and to make choices. Success may be measured not by the presence or absence of pain, but by the degree to which a patient’s productivity increases.

For example, over a period of years Erickson treated a young man with Charcot-Marie-Tooth disease, a debilitating and progressive neuromuscular condition responsible for an ongoing, more or less continuous experience of pain and loss of muscular function. The friendly, congenial young man became friends with several of the Erickson family members. Recently John shared his insight into how Erickson helped him to adapt to his condition. John described that prior to working with Erickson, he had developed a coping mechanism of focusing. The focusing process, an intense concentration on the present task, was consuming. It was so well developed that while focusing, John actually experienced tunnel vision.

The handicap of that adaptation technique is that once consumed by the process, it is possible to become totally unaware of the world around—like a poor reader who gets stuck on a single word, the eyes keep moving and the mouth speaks, but the content is lost. The attention is latched on that single word.

John stated, “Because pain can happen to me at any time of the day or night, Erickson taught me to take advantage of the times when I feel reasonably O.K. to be productive. One learns to pick up on the early signs, to ease up, to divert attention, and when the down time passes to become productive again and not look back.”

John continued: “I’m a slow worker, and I now realize that it is because I take a lot of short breaks, turning away for a minute to collect my strength. It takes a lot of patience. One of the greatest values that Erickson taught me was patience: letting the moment develop instead of forcing it into a predetermined shape. I am not a patient person, but I have learned to work within that framework effectively.”

John went on to say, “He taught me to distinguish deliberate bursts of focused attention from the habitual overfocus that I used. I think there is a broad reach to what that distinction can mean to life skills. I have adapted to a different type of world view.”
This technique, as with all others used by Erickson, was tailored specifically to meet the needs, personality, and life-style of this intellectual and literate young man.

**Division into Parts**

Pain is often a variable sensation, waxing and waning over time, sometimes in an identifiable pattern. It is apart from, yet becomes a part of the identity of, the part with which it is associated.

Pain can be separated temporally from the past injury, event, or onset, and from past memory of similar pain experiences. The past memory of a painful injection, or an unpleasant visit to the dentist, may generate negative anticipation. The past memories of pain blend into the future expectation of pain. Anticipation produces muscle tension, an endocrine response, and a cardiovascular response, all of which actually contribute to the negative impact of the injury.

The burden of past memories and future expectations can overwhelm and overshadow the present, interfering with perceptions and with coping mechanisms. On the other hand, most people have at least one memory of an occasion in which pain was experienced and then the sensations faded. Inquiring about occasions in the past in which the resolution process successfully evolved may reframe current events. At the least, it will serve as a reference to validate the existence of such a phenomenon.

The experience of pain can be teased apart from the grief that may be associated with the cause of the pain. It may be separated from the burden of past memories and from future expectation of more pain. Once relieved from that entanglement, the present experience of pain is a much less formidable threat. Broken down, moment by moment, even the most monumental of trials can be tolerated.

Reorienting to the present moment, experiencing the sensations as they occur, unencumbered by unessential cargo, the subject frees his or her resources to attend to the task of mending, healing, and comforting.

For example, separation of the present from the past and future and time distortion were the two key elements in the preparation that Erickson did with me for my anticipated childbirth needs. From the time I was 12 or 13, Dad would ask me what I would like to work on hypnotically. General pain control and labor/delivery were my favorite topics even at that young age. What I remember consciously from that
trance work is not words. I have a visual image of a line, in wave form. I can see the peaks and valleys along the line and understand that the peaks represent the muscle contractions (discomfort). As I watch that line, I can see the valleys (periods of relaxation, comfort) extend out sufficiently to provide rest. The peaks sharpen up, the intensity and the sensation remain intact, but anticipation of discomfort is transformed into the expectation of only a brief moment of pain, followed by a comfortable rest. The emphasis is on enjoying the “good times,” perceptually stretching them, while simultaneously diminishing “bad times” by perceptually narrowing them.

Pain also can be divided spatially. Identification of the area affected by the sensation delineates those areas where pain is distinctly felt from those areas where there is a less clear feeling and from those areas free of pain. The investigation process itself may narrow the affected area. Once identification of a pain-free area is achieved, a reference is provided. Self-image entails a feeling of connection with one’s own body and a feeling associated with what “normal” or “usual” or “healthy” feels like. The experience of pain within the body part that is damaged or injured may be a reasonable adaptation to the current situation. Removing pain may expose the part to additional risk or trauma. However, it is not always necessary to continue with a large area of pain when a smaller area will achieve the same degree of protectiveness. By using one’s imagination, e.g., through positive visual hallucinations, one may draw a barrier, separating the “hurting part” from the “part that does not hurt.” Once that division is firmly set in one’s mind, movement of the barrier slowly can advance in the direction that affords the maximum comfort to the rest of the body.

For example, while working at a county hospital we saw numerous “wreinger” injuries. Small children playing with an old-fashioned wringer washer can get their arm drawn into the wringer mechanism. The injury typically produces a crushing type of trauma to the entire arm, including the shoulder, and treatment includes elevation of the affected part. The children often are hospitalized, and the arm suspended from an ambulatory intravenous pole. I worked with one of these children and produced a long glove anesthesia, which was effective. On a subsequent case, after consulting with Erickson, I utilized an approach of drawing an imaginary line across the shoulder to the level that the pain extended. I then worked with the child to advance that line distally. Over a period of several hours, the discomfort was pulled back to below the elbow. I did not advance the progress further because the injured limb did require the protection that pain commands.
Dissociation

There are various modalities within which dissociation can be achieved. Perceptual analgesia, anesthesia, and amnesia are all mechanisms that dissociate the patient from the sensation and shield the patient from the negative impact of the pain. All are creative mechanisms for setting the pain aside and expanding perceptual response options.

Separation. The patient may experience the pain, in its intact form, in a different location from the affected part. The patient is thereby released from identifying with the painful experience. The entity of pain is accepted as a part of the present experience, but the patient mutates the perception of pain, interpreting the sensations as occurring in a less vulnerable part of the body. The process of pain, or the procedures initiating the pain, diminish to an element over which some control may be executed. The invasion of the self by these agents is reduced, and the patient attains control by manipulating or juggling the perceptual process.

For example, when I was a child, I suffered from relatively soft enamel on my teeth. Despite a reasonable diet and regular toothbrushing, it seemed as if I had cavities on every visit to the dentist. I know that I received novocaine at least once, and Erickson was not against my receiving standard medical or dental care as it was offered. I distinctly remember him emphasizing the importance of making a choice: Was it the dentist’s decision as to whether I would receive the injection, or was it my choice? Whatever choice I made was O.K., as long as it was mine. He then enlightened me as to other choices, and to how to use them.

On a later visit to the dentist, following his suggestion, I did try focusing all of my pain receptors into my hand. It was not an entirely satisfactory experience. Initially I targeted my right hand, which was continually at risk because the dentist sat on that side of me. I was terrified that the dentist, unaware of the hypersensitivity of my hand, would inadvertently bump into it. With tremendous effort I switched over in “midstream” to my left hand. It was not satisfactory for me to have spent the entire time “worrying about my hand,” a feeling that was NOT comforting to me.

When I reported back to Erickson, he suggested that on a future visit I “see myself across the room, watching the dentist from over his own shoulder.” This proved a much more satisfactory perspective for me, and I have used it successfully over the years. Having a roving perspective allows me to go inside and feel, when I want, and to escape easily when that is my choice.
Transformation

The sensation of pain can occur suddenly, unexpectedly, or abruptly; or it can occur in a gradual fashion, building up, waxing and waning, or coexisting as a presence of its own. Both contain mechanisms that may be useful. The sudden pain offers a more complete respite, while the ongoing pain may more effectively prepare the patient to cope with the sensation. With an ongoing experience there is more of an opportunity to approach and alter the perceptual sense.

One approach may be to enlarge and diffuse or dilute the pain over a larger area. Another approach would be to transform the pain sensation into a more intense experience. An unexpected intervention, such as suggesting more discomfort, initiates control and supplies the reference for reframing. Encouraging the patient to “go back and feel the pain as it was before the intensification” perceptually reframes the experience into one of relative comfort.

Variations of transformation are limited only by the imagination of the participants and can involve any of the sensory modalities. Recurrent sensations offer a great deal of opportunity for transformation into experiences that are more acceptable to the patient. The process of learning to alter the sensations and reinterpret stimuli may be sufficiently engrossing to envelop the patient and provide an interim distraction engrossing enough to meet current needs.

For example, while I was working at a large county hospital in the pediatric emergency area, there were a few children who came in with disseminated coccidioidomycosis, a serious internal fungal infection. They were treated as outpatients with triweekly intravenous infusions. The treatments lasted several hours and were generally unpleasant. The drug used sometimes produced a local burning sensation at the site, nausea, dizziness, and an overall sick feeling. Particularly distressing was the fact that duration of treatment may be indefinite, and at times little or no positive response is apparent. Since then, more promising drugs have been developed to treat the condition.

One child with whom I had contact over a period of time described the sensation of the intravenous infusion to me in vivid, colorful language. The colorless liquid was described by Jerry as being fiery red, burning the bottle, and creeping down the tubing, biting his forearm and painting his body in a systematic sequence, until he himself became all red, “like the devil.”

Slowing the intravenous infusion and soothing the child seemed so insufficient that I consulted Erickson for advice prior to the next treatment. Over the next few treatments, I developed an intense interest in the phenomenon of color, wondering how bright the color really was,
and eliciting an exacting description of the repetitive process. I began to question the experience and to "seed" questions, like "Is it always such a bright color of red?" and "I wonder how it would feel if it were another color?"

After a short period of time, we discovered that the drug remained "red" but that Jerry could look at it "as if it were green," and by so doing, could paint himself ahead of the medicine's own "painbrush." At the time I left that position, Jerry was still coming in regularly and seemed to be more comfortable before and during his treatments.

Another example of utilizing transformation is an incident that happened to me when I was about five or six years old. My older brother, Lance, and I had collided in a doorway and the impact of the door removed the nail from my big toe. I was crying and upset, particularly because Lance did not express what I felt was sufficient remorse for something I perceived to be clearly his fault.

At this age, Erickson had not yet begun working with me in a formal capacity, but he called me into his office. Somehow he convinced me that if Lance would lift me up on his shoulders, I would find on the ceiling an off/on switch. I was not to tell Lance what I was looking for. Once Lance lifted me, I could find and retrieve the switch. Having obtained the imaginary switch I was free to install and operate it in whatever manner I chose.

As I came out of the office, Lance cheerfully complied with my request to ride on his shoulders. I recall finding the imaginary switch with no difficulty and puzzled only over whether it would be more effective inside or outside of my clothing.

The result of the intervention was that my toe stopped bothering me, and my bad feelings about Lance were "uplifted" into feelings that he had helped me.

Resolution

The healing process follows a natural, rather predictable course. Investigation of a wound offers a chance to see those parts normally hidden and an opportunity to explore the healing process in action. Familiarity with those steps of the healing process, and with actions that can be taken to reduce risk at each step, can enhance the healing.

For example, when I was a teenager, Erickson utilized me to work with one of his patients, a white-haired, overweight lady with stooping posture. We spent a number of afternoons together and she described to me, in detail, the arduous experience of her mastectomy. She had been
left with residual pain and swelling in her shoulder and arm. One part of her therapy involved research about the Grand Canyon. She had been assigned to go to the public library to research the Grand Canyon. Apparently she had not successfully completed her homework, and so my role was to tutor her in the use of the library. I was paid a minimal hourly wage and walked with her to the library, showed her how to use the card catalogue, and sat with her while she read to me about the Grand Canyon. We would then walk back to the office and together report to Erickson. He would then quiz each of us about what we had noticed about the walk, the afternoon, and the library. This took place over several days.

Initially I noticed that I seemed to be more aware of the beauty and pleasure of the walk than she was. Later I noticed that Erickson seemed to shift emphasis from the immediate surroundings to the grandeur of the canyon. He talked about the tall mesas that rise above the canyon floor, straight and elegant. I recall the emphasis on the running water that, when blocked, developed alternate collateral routes. He described in detail the beauty of erosion, as it takes place in harmony with the strength of the pillars—the changes that occur over time, and the elegance in each tiny change.

I was aware that this lady suffered from diminished enthusiasm about life. I pondered how her homework could have addressed the problems she described to me. However, as a child and employee of my father, I took my role seriously. My role included “no questions.” Retrospectively, I have a better understanding of the physiological issues that were being addressed in the analogies. I suspect that by drawing attention to the beauty and the grandeur of the canyon, Erickson was facilitating the development of a broader outlook on life. The analogies of the tall mesas may have addressed her stooping posture and perhaps the collateral flow provided suggestions to enhance the lymph flow in her affected shoulder. It is speculative because the case was never written up, and to my knowledge, it was never discussed professionally.

Many years later, my mother encountered the lady in a social setting. Mom observed that the woman was attending a dog show with her granddaughter and seemed to be interested in the outdoor activity. I regret that I cannot offer more concrete information as to the outcome of that therapy.

**SUMMARY**

These interventions can be combined to produce an almost limitless repertoire of approaches to solve any pain problem. I have reviewed the
Applications of hypnosis in pain control that were described by Erickson. I have presented five broad categories within which the applications described by Erickson can be flexibly used. It is my hope that the broad categories provide a framework for the creative advancement of hypnotic interventions.

As in any hypnotic work, it is necessary to tailor the suggestions and imagery to meet the personal needs of the patient. A technique suitable for one patient may be entirely unsuitable for the next, even though the problem may appear similar. Most therapeutic work with pain requires a delicately woven tapestry of interventions, a unique combination suitable specifically for that patient, at that time.

The effectiveness of interventions depends largely on the preparedness of the patient and the manner in which the suggestions are woven into the trance experience. The patient's ability to make use of suggestions may depend on his or her current receptivity and on the extent to which the therapist has included future-oriented posthypnotic suggestions.

One of the fundamental qualities of Ericksonian psychotherapy is that, though the final therapeutic mechanism may appear simplistic, the preparation and study by the therapist are, in contrast, complex. Complexity is clearly a consideration in the utilization of pain control techniques. The individual patient, with his or her particular background, personality, and individual perception of pain, must be carefully considered in the development of an effective treatment plan. The pain management must be harmonious with the patient's medical treatment and lifestyle.

Finally, the therapist must remain acutely attuned to the consideration that pain signals are a valuable source of information—a warning of disease or injury, or a signal for protection. A major responsibility of any therapist who undertakes to diminish the patient's response to pain is training the patient to recognize and heed warning signals that are now masked or diminished.

The more psychologically comprehensive the approach, the greater the likelihood of therapeutic results. Erickson believed that continued investigation into the phenomena of pain and into the process of pain management would eventually reveal tools for the empirical measurement of both. He also believed that as understanding of these progressed, mystique would yield to explanation.

REFERENCES

